DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/15/15

PRINTED: 07/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445126	A. BUILDING _____ B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SEQUATCHIE	360 DELL TRAIL, PO BOX 878 DUNLAP, TN 37327

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F 000	INITIAL COMMENTS A recertification survey and complaint investigation #36724 and #36530, were completed on June 29 through July 1, 2015, at NHC Healthcare, Sequatchie. No deficencies were cited related to complaint investigation #36530. A deficiency was cited related to complaint investigation #36724, under 42 CRF Part 483, Requirements for Long Term Care Facilities.	F 000	The Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed failed to arrange vision care for 1 resident (#141) and failed to provide a sufficient discharge for 1 resident (#173) of 30 residents reviewed. The findings included: Review of facility policy, Eye Care, reviewed and revised 7/15 revealed "...Nursing Staff assesses the resident's eye care needs...referral to the Social Worker [SW] who arranges the appointment...requests may also be made by the resident..." Medical record review revealed Resident #141	F 250	1. Upon the discharge of Resident #141 to a boarding home under the care of Hospice of Chattanooga on 7/17/15, Hospice of Chattanooga will arrange for an eye examination and treatment as needed. 2. All residents have been assessed for vision care needs and referrals made if needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADM 7/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	Continued From page 1 was admitted to the facility on 12/26/15 with diagnoses Chronic Obstructive Pulmonary Disease and Lung Nodule. Medical record review of a Quarterly Minimum Data Set (MDS) dated 4/13/15 revealed "...Moderate limited vision..." Medical record review of a Care Plan dated 4/21/15, "...has had glasses for 40 years and does not see well with them. Social Services to arrange for resident to be seen...for an eye exam..." Interview with Resident #141 on 6/29/15 at 3:49 PM, in the resident's room revealed the resident had requested to see an eye doctor "8 weeks ago" and no arrangements had been made. Interview with the SW on 6/30/15 at 3:22 PM, in the Employee Break Room revealed the resident had requested to see an eye doctor during the Care Plan Meeting on 4/21/15 (70 days ago). Continued interview confirmed the facility failed to make arrangements for an eye appointment. Medical record review revealed Resident #171 was admitted to the facility on 6/2/15 with diagnoses including Senile Degeneration of Brain, Hospice Care, and Congestive Heart Failure. Medical record review of a Social Services note dated 6/5/15 revealed "...Pt [patient]...for 5 day respite stay through...Hospice...will discharge home with daughter...on 6/7/15 [no time]..." Medical record review of the Discharge Plans dated 6/3/15 revealed "...the ambulance service will pick up the patient in the evening of June 7th	F 250	3. All residents will be assessed for vision care within the first 14 days of admission and referrals made as necessary. Resident or family may also request referral for vision care. Social Worker will assure each referral is acted upon and document in the medical record. Care Plan Nurse will keep a log of all vision care referrals. The Social Worker will complete the log with the date of the examination or explanation of why the examination was not done. 4. The Director of Nursing and the Director of Social Work will review the log monthly and report to the Quality Assurance committee for 3 months or until there is 100% compliance.	7/27/15

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F 250	Continued From page 2 and transport her home...time of the transport will be approx. [approximately] 7 p.m. per [hospice]..." Medical record review of a Post Discharge Instructions dated 6/7/15 revealed "...Date of Discharge 6/7/15 [no time]...total depend [dependent] with all ADL's [activities of daily living] and transfers..." Medical record review of a Discharge Summary dated 6/7/15 revealed "...unable to voice needs..." Interview with Resident #171's daughter on 6/30/15 at 6:49 PM, by telephone revealed the daughter had been returning from Florida on 6/7/15 (day of discharge) and had made arrangements with the facility and hospice for the resident to return home at 7:00 PM. Continued interview revealed the daughter phoned the facility on 6/7/15 at 8:00 AM, and the nurse informed the daughter the resident was discharged at 7:00 AM by ambulance to the daughter's house (1.5 hours from facility). Further interview revealed no caregiver was at the home, the resident was unable to stay alone, and the resident had to stay on the ambulance stretcher until a sitter could arrive. Interview with the SW on 7/1/15 at 9:00 AM, in the Director of Nursing (DON) Office revealed the Post Discharge Instructions were placed at the Nurses Station on 6/5/15 (Friday), the resident was scheduled for discharge on 6/7/15 (Sunday in the PM), and the instructions had not included the time of discharge. Continued interview confirmed the facility failed to notify nursing of the 7:00 PM discharge and the resident was discharged at 7:00 AM by ambulance to the daughter's home with no caregiver present.	F 250	**1. Resident #173 (erroneously referred to in the CMS-2567 as Resident #171) has been discharged home.** **2. All Post Discharge Instructions involving any resident being transported by ambulance, will have a time of transport noted.** **3. Social Worker will verify all ambulance transport of discharge residents even if set up by another agency.** **4. The Director of Social Work will review all Post Discharge Instructions to assure accuracy and report to the Quality Assurance committee for 3 months or until there is 100% compliance.**	7/27/15

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F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to assist 1 resident (#141) to obtain eye care of 30 residents sampled. The findings included: Review of facility policy, Eye Care, reviewed and revised 7/15 revealed "...Nursing Staff assesses the resident's eye care needs...referral to the Social Worker [SW] who arranges the appointment...requests may also be made by the resident..." Medical record review revealed Resident #141 was admitted to the facility on 12/26/15 with diagnoses Chronic Obstructive Pulmonary Disease and Lung Nodule. Medical record review of a Quarterly Minimum Data Set (MDS) dated 4/13/15 revealed "...Moderate limited vision..." Medical record review of a Care Plan dated	F 313	1. Upon the discharge of Resident #141 to a boarding home under the care of Hospice of Chattanooga on 7/17/15, Hospice of Chattanooga will arrange for an eye examination and treatment as needed. 2. All residents have been assessed for vision care needs and referrals made if needed. 3. All residents will be assessed for vision care within the first 14 days of admission and referrals made as necessary. Resident or family may also request referral for vision care. Social Worker will assure each referral is acted upon and document in the medical record. Care Plan Nurse will keep a log of all vision care referrals. The Social Worker will complete the log with the date of the examination or explanation of why the examination was not done. 4. The Director of Nursing and the Director of Social Work will review the log monthly and report to the Quality Assurance committee for 3 months or until there is 100% compliance.	7/27/15

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F 313	Continued From page 4 4/21/15, "...has had glasses for 40 years and does not see well with them. Social Services to arrange for resident to be seen...for an eye exam..." Interview with Resident #141 on 6/29/15 at 3:49 PM, in the resident's room revealed the resident had requested to see an eye doctor "8 weeks ago" and no arrangements had been made. Interview with the Social Worker (SW) on 6/30/15 at 3:22 PM, in the Employee Break Room revealed the resident had requested to see an eye doctor at the Care Plan Meeting 4/21/15 (70 days ago). Continued interview confirmed the facility failed to make an appointment with an eye doctor for the resident.	F 313		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of facility's resident list for dental services, medical record review, observation, and interview, the facility failed to arrange dental services for 2	F 412	**1. Upon the discharge of Resident #141 to a boarding home under the care of Hospice of Chattanooga on 7/17/15, Hospice of Chattanooga will arrange for a dental examination and treatment as needed.** **2. All residents have been assessed for dental care needs and referrals made if needed.**	

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F 412	Continued From page 5 residents (#141, #156) of 3 residents reviewed for dental of 30 residents sampled. The findings included: Review of facility policy, Dental, revised 2/14 revealed "...each resident evaluated on admission, quarterly, and as needed for dental services..." Review of the facility's resident list for dental services, dated 4/16/15 revealed the list of names of the facility residents who received dental services on 4/16/15. Further review revealed Resident #141 and #156 was not listed. Medical record review revealed Resident #141 was admitted to the facility on 12/26/15 with diagnoses Chronic Obstructive Pulmonary Disease, Alcohol Abuse, and Tobacco Dependence. Medical record review of a Significant Change Minimum Data Set (MDS) dated 1/15/15 revealed "...obvious or likely cavity or broken natural teeth..." Medical record review of a Nutritional Assessment Report dated 1/15/15 revealed "...Teeth...Gray-brown spots, missing or erupting abnormally..." Medical record review of the Consent for Dental Treatment dated 4/3/15 revealed "...I consent for dental treatment..." Medical record review of a Care Plan dated 4/21/15, "...self care deficit...assist with set up for oral/dental hygiene..."	F 412	3. All residents will be assessed for dental care within the first 14 days of admission and referrals made as necessary. Resident or family may also request referral for dental care. Dental Care Coordinator upon receiving a request for dental care will obtain a consent form for care and physician's order for care. The Dental Care Coordinator will fax the consent form, physician's order and resident's face sheet with insurance information to the Mobile Dental Services. The Mobile Dental Services verifies insurance, works with the resident and family and makes appointments. In the case of emergency care, the Dental Care Coordinator contacts the Mobile Dental Services by phone to make an immediate appointment. If the Mobile Dental Services cannot provide immediate services, an appointment is made with a local dentist. 4. The Director of Nursing will review all Dental Referrals to assure dental services are provided to all residents requesting the care and report to the Quality Assurance Committee monthly for 3 months or until there is 100 % compliance.	7/27/15

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F 412	Continued From page 6	F 412		

Observation and interview with Resident #141 on 6/29/15 at 3:49 PM, in the resident's room revealed "I have constant teeth pain." The resident had requested to see the dentist, no arrangements had been made, and he had signed a "paper."

Interview with Licensed Practical Nurse (LPN #1) on 6/30/15 at 4:00 PM, in the Wound Care office revealed LPN #1 faxed the census to the Mobile Dental Services and the Dental Services faxed consents back to the facility. The LPN is unaware of how residents are placed on the list to see the dentist. Continued interview revealed the dentist visited the facility on 4/16/15 and Resident #141 had not received dental services.

Interview with the representative from the mobile dentistry, on 6/30/15 at 4:15 PM, by telephone revealed the facility had not returned the consent form back to the dental services in time for the resident to see the dentist on 4/16/15.

Interview with the Director of Nursing (DON) on 7/1/15 at 9:15 AM, in the DON Office revealed the consent must be returned to the dentist within 10 days of the scheduled visit. Continued interview confirmed the facility had failed to arrange dental services for Resident #141.

Resident #156 was admitted to the facility on 3/9/15 with diagnoses including Left Cerebral Vascular Accident with Weakness, Cognitive Deficit, Anxiety, Traumatic Brain Injury, and Peripheral Vascular Disease.

Medical record review of the Admission Minimum

1. Resident #156 is scheduled to be seen by Mobile Dental Services on 7/24/15.

2. All residents have been assessed for dental care needs and referrals made if needed.

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F 412	Continued From page 7 Data Set, dated 3/16/15 revealed "obvious or likely cavity or broken natural teeth." Medical record review of the Consent for Dental Treatment, not dated revealed the Power of Attorney signed the consent for dental services on 4/3/15 for Resident #156. Observation of Resident #156, on 6/29/15 at 12:25 PM, in the resident's room revealed poor dentition with a discolored upper tooth and missing and rotten bottom teeth. Interview with Resident #156 on 6/29/15 at 12:25 PM, in the resident's room confirmed no dental services since admission to the facility "...look at my teeth..." Interview with LPN #1 on 6/30/15 at 2:00 PM, at the Station 2 nursing station confirmed she was responsible for evaluation of residents for dental care. Continued interview confirmed LPN #1 failed to place the resident on the list for dental services. Interview with the DON on 6/29/15 at 3:00 PM, in the DON office confirmed the facility failed to provide dental services for Resident #156.	F 412	**3. All residents will be assessed for dental care within the first 14 days of admission and referrals made as necessary. Resident or family may also request referral for dental care.** **Dental Care Coordinator upon receiving a request for dental care will obtain a consent form for care and physician's order for care. The Dental Care Coordinator will fax the consent form, physician's order and resident's face sheet with insurance information to the Mobile Dental Services. The Mobile Dental Services verifies insurance, works with the resident and family and makes appointments.** **In the case of emergency care, the Dental Care Coordinator contacts the Mobile Dental Services by phone to make an immediate appointment. If the Mobile Dental Services cannot provide immediate services, an appointment is made with a local dentist.**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**4. The Director of Nursing will review all Dental Referrals to assure dental services are provided to all residents requesting the care and report to the Quality Assurance Committee monthly for 3 months or until there is 100 % compliance.**	7/27/15

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F 514	Continued From page 8 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, and interview, the facility failed to ensure the accuracy of a Physician Orders for Scope of Treatment (POST) for 1 resident (#141) of 30 residents reviewed. The findings included: Review of facility policy, DNR (Do Not Resuscitate), no date revealed "...The Physician Orders for Scope of Treatment [POST]...the Universal DNR order...Section A...at a minimum, must be completed..." Medical record review revealed Resident #141 was admitted to the facility on 12/26/14 with diagnoses including Exacerbation of COPD and Right Lung Nodule. Medical record review of the Quarterly Minimum Data Set (MDS) dated 4/13/15 revealed "...Special Treatments...Hospice..." Medical record review of the Care Plan dated 4/21/15 revealed "...terminal dx [diagnosis]...Hospice...assess the residents desires/wishes related to end of life..." Medical record review of an Advance Care Plan	F 514	1. The Physician Orders for Scope of Treatment (POST) Form was correct for Resident #141 prior to his discharge on 7/17/15. 2. All residents' POST Forms have been reviewed for accuracy and corrections made as necessary. 3. All residents' POST Forms will be reviewed upon admission for accuracy. A log will be kept of all POST forms that are incomplete to assure the form is completed correctly as soon as possible. 4. The Director of Nursing will report to the Quality Assurance committee for 3 months or until there is 100% compliance.	7/27/15

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F 514	Continued From page 9 dated 1/12/15 revealed "...Treatment...By marking no below I have indicated treatment I do not want..." Continued review revealed the "No box" had been marked for CPR (Cardiopulmonary Resuscitation). Medical record review of the Post Form dated 1/12/15, revealed "...Section A check one box only..." Continued review revealed the Post Form had 2 boxes. Box 1, Resuscitate, Box 2, Do Not Resuscitate, both boxes had been checked, and the Resuscitate box was checked and circled. Medical record review of a Physician's order dated 1/20/15 revealed "...Instructions: DNR..." Interview with the Director of Nursing (DON) on 6/30/15 at 3:58 PM, in the DON Office confirmed the facility failed to accurately complete the Post Form for Resident #141.	F 514		